	ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTIÓN 601 - MAIN BUILDING 01	(X3) DAT COM	. 0938-(E SURVE MPLETED
LAKEBRIDGE HEALTH CARE CENTER (KA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FILL REGULATORY OR LIGE IDENTIFYING INFORMATION) K 018 NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by. Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed corridor doors to residents rooms 205 and 510 failed to close to a positive latch. Monitoring REGULATORY OR LECENCY MISTARD PROPRIATE COMMENT TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROPRIMERY PLAND CORRECTION (EACH CORRECTION (EACH CORRECTION CERCITON) (EACH CORRECTION CERCITON) (EACH CORRECTION CERCITON) REGULATORY OR LISC IDENTIFYING INFORMATION) K 018 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Areas Corridor doors to resident rooms 205 and 510 were adjusted on 7/22/13 and were found to be latching properly. Measures to assure compliance include monthly Performance improvement audits by the Administrator and Maintenance Director to insure doors latch, properl	NAME OF		445358	B. WING		07/	16/201
SALMARY STATEMENT OF DEFICIENCIES PROVIDERS PLANOF CORRECTION CRESULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			CENTER	1	15 WOODLAWN DRIVE	DDE	
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3. Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensuire corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed corridor doors to residents rooms 205 and 510 failed to close to a positive latch.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE EAPPROPRIATE	(XS COMPLI DAT
This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed corridor doors to residents rooms 205 and 510 failed to close to a positive latch.	K 018 SS=D	Doors protecting correquired enclosures hazardous areas are those constructed of wood, or capable of minutes. Doors in sirequired to resist the no impediment to the are provided with a rifthe door closed. During the construction of the constructi	rridor openings in other than of vertical openings, exits, or e substantial doors, such as 134 inch solid-bonded core resisting fire for at least 20 prinklered buildings are only a passage of smoke. There is a closing of the doors. Doors means suitable for keeping tch doors meeting 19.3.6.3.6	K 018	Lakebridge Health Care Ce its current practices were i with the applicable standa but in order to respond to from the surveyors, the facthe following additional ac	n compliance rd of care, this citation cility is taking tions:	
This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed corridor doors to residents rooms 205 and 510 failed to close to a positive latch. Systematic Changes Measures to assure compliance include monthly Performance Improvement audits by the Administrator and Maintenance Director to insure doors latch properly. Monitoring Results of these audits will be reported monthly to the Performance		Roller latches are proin all health care faci	ohibited by CMS regulations lities.	· ·	7/22/13 and are latching Identification of Other Area Potential to be Affected Facility doors, in addition to and 510, were checked by Maintenance Director on 7,	properly. s with rooms 205 the /22/13 and	
	- -	Based on observation determined the facility doors closed to a post 19-3.6.3.) The findings include: Observation and inter Director, on July 15, 211:00 p.m. confirmed rooms 205 and 510 face.	n and interview, it was y failed to ensure corridor itive latch. (NFPA 101, view with the Maintenance 2013 between 7:20 p.m. and corridor doors to residents		Systematic Changes Measures to assure complia monthly Performance Improaudits by the Administrator Maintenance Director to inslatch properly. Monitoring Results of these audits will be	nce include ovement and ure doors	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 50LV21

Facility ID: TN9008

Jecontinuation sheet Page 1 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN (ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		445358	B. WING			07/16/2013	
LAKEBR	NAME OF PROVIDER OR SUPPLIER LAKEBRIDGE HEALTH CARE CENTER			1	REET ADDRESS, CITY, STATE, ZIP CODE 15 WOODLAWN DRIVE OHNSON CITY, TN 37604	, ,,,	
(X4) ID PREFIX TAG	{EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 018 SS=D	Doors protecting concequired enclosures hazardous areas are those constructed of wood, or capable of minutes. Doors in strequired to resist the no impediment to the are provided with a the door closed. Durare permitted.	pridor openings in other than sof vertical openings, exits, or se substantial doors, such as of 1% inch solid-bonded core resisting fire for at least 20 sprinklered buildings are only a passage of smoke. There is see closing of the doors. Doors means suitable for keeping atch doors meeting 19.3.6.3.6.3.6.3.	K	018	and recommendations. The Perforance Improvement Committee corof the Administrator, Medical Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, Social Services Director. The Committee's recommendations will be follow by the Administrator and the Maintenance Director.	nsists ector, ector and and	7/26/13
		÷	<i>:</i>				
	Based on observati determined the facili	not met as evidenced by: on and interview, it was ity failed to ensure corridor sitive latch. (NFPA 101,			· ·		
	Director, on July 15, 11:00 p.m. confirmed	erview with the Maintenance 2013 between 7:20 p.m. and d corridor doors to residents failed to close to a positive					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445358 B. WING 07/16/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE LAKEBRIDGE HEALTH CARE CENTER JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 018 Continued From page 1 K 018 These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013. NFPA 101 LIFE SAFETY CODE STANDARD K 021 K 021 K 021 SS≃D Any door in an exit passageway, stairway Lakebridge Health Care Center believes enclosure, horizontal exit, smoke barrier or its current practices were in compliance hazardous area enclosure is held open only by devices arranged to automatically close all such with the applicable standard of care. doors by zone or throughout the facility upon but in order to respond to this citation activation of: from the surveyors, the facility is taking the following additional actions: a) the required manual fire alarm system: Corrective Actions for Targeted Areas b) local smoke detectors designed to detect smoke passing through the opening or a required Fire doors from the dining room, back smoke detection system; and hall, and by room 510 were repaired by the facility Maintenance Director on c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 7/16/13, and they close to a positive latch when the facility's fire alarm is activated. Identification of Other Areas with Potential to be Affected This STANDARD is not met as evidenced by: Fire doors, in addition to those listed Based on observation and interview, it was above, were checked by the determined corridor fire doors were held open by approved devices. Maintenance Director on 7/18/13 The findings include: and 7/22/13, and were found to be Observation and interview with the Maintenance latching properly. Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed both pairs of fire doors from dining room, back hall, and the fire doors by room 510 would not close to a positive latch. These findings were verified by the Maintenance

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 50LV21

Facility ID: TN9008

If continuation sheet Page 3 of 12

JUL 25 2013

JUL 24 2013

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				E SURVEY PLETED
		445358	B. WING			07/	16/2013
	ROVIDER OR SUPPLIER	CENTER		11	EET ADDRESS, CITY, STATE, ZIP CODE 15 WOODLAWN DRIVE OHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029 SS=D	15, 2013. NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 prothe approved automoption is used, the aother spaces by sm doors. Doors are sfield-applied protect.	rnowledged by the g the exit conference on July FETY CODE STANDARD construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from toke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K 0:		Systematic Changes Measures to assure compliance incomonthly Performance Improvemer audits by the Administrator and the Maintenance Director. They will also to ensure doors latch properly when the fire alarms are activated. Monitoring The Maintenance Director will report the results of these audit monthly to the Performance Improvement Committee for results and recommendations. This	nt e udit en s	
K 038 SS≃E	Based on observat determined the facil larger than 50 squal combustible material closers. The findings include Observation and into Director, on July 15, the Clinical records with a door closer. This finding was ver Supervisor and acknowledge Administrator during 15, 2013.	erview with the Maintenance 2013 at 9:00 p.m. confirmed room door was not provided ified by the Maintenance	K 03	38	Committee consists of the Administrator, Medical Director, Director Nursing, Assistant Director of Nursing, Assistant Director of Nursing Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed by the Administrator and the Maintenance Director to assure compliance. K 029 Lakebridge Health Care Center belief its current practices were in complimit with the applicable standard of care	of ing, s up te- e.	

CENTE	<u>RS FOR MEDICARE</u>	AND HUMAN SERVICES & MEDICAID SERVICES	· .	FORM): 07/18/201; APPROVEI): 0938-039;
STATEMENT AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3) DA	TE SURVEY MPLETED
<u> </u>		445358	B. WING_		14010040
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	/16/2013
LAKEBR	RIDGE HEALTH CARE	CENTER		115 WOODLAWN DRIVE JOHNSON CITY, TN 37604	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(XS) COMPLETION DATE
K 021	Continued From pa Supervisor and ack Administrator during 15, 2013.		K 02	but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	
K 029		FETY CODE STANDARD	K 02	Corrective Actions for Targeted Areas	
SS≈D	One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 prot	construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When		A door closer was installed by the facility Maintenance Director on the clinical records room door on 7/18/13.	
	the approved autom option is used, the a other spaces by sm	natic fire extinguishing system areas are separated from oke resisting partitions and		Identification of Other Areas with Potential to be Affected	
	doors. Doors are se field-applied protect	elf-closing and non-rated or ive plates that do not exceed pottom of the door are		Other doors that require a door closer were audited by the facility Maintenance Director on 7/18/13, and were found to be in compliance.	
			•	Systematic Changes	
	Based on observati determined the facili larger than 50 squar combustible materia	not met as evidenced by: on and interview, it was ty failed to ensure rooms e feet, used to store ls, were provided with door		The Maintenance Director was inserviced by the facility Administrator on 7/18/13 regarding the requirement for positive latch door closers.	
	closers. The findings include			Monitoring	
	Observation and inte Director, on July 15, the Clinical records r with a door closer. This finding was veri Supervisor and ackn Administrator during	erview with the Maintenance 2013 at 9:00 p.m. confirmed coom door was not provided fied by the Maintenance	.A.	The Maintenance Director will audit facility doors monthly for three months to assure that doors requiring door closers are in compliance. Results of the audits will be reported to the Performance Improvement Committee for review and recommendations. This	
	15, 2013. NFPA 101 LIFE SAF	ETY CODE STANDARD	·K 038	Committee consists of the Admin-	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:50LV21

Facility ID: TN9008

If continuation sheet Page 5 of 12



STATEMEN	T OF DEFICIENCIES	CAL PROPERTIONS				MB NO	D. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01		TE SURVEY
NAMEOR		445358	B. WING	·		07	7/16/2013
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID	1	REET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE JOHNSON CITY, TN 37604 PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RF	(XS) COMPLETION DATE
K 045 SS≃D	This STANDARD is Based on observation determined the facility twelve (12) delayed upon activation of the Findings include: Observation and interpretation of the Maintenance Dingerous of the Maintenance Observation and interpretation of the Administrator during the Therapy gym delayed operate. These findings were supervisor and acknown of the Maintenance of the Therapy gym delayed operate. These findings were supervisor and acknown of the Maintenance of the Maint	ged so that exits are readily es in accordance with section not met as evidenced by: on and interview, it was ty failed to ensure eight (8) of egress doors would release e fire alarm. Erview during the fire drill with ector, on July 15, 2013 at exit doors with netic locking hardware failed arm activation by the beauty 208, 713, kitchen exit, by main entrance and dining staff interviewed did know go the doors. Layed egress function failed eyerified by the Maintenance owledged by the the exit conference on July early CODE STANDARD of egress, including exit d so that failure of any single will not leave the area in not refer to emergency	K 04	5	Nursing, Assistant Director of Nursing Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed by the Administrator and the Maintenance Director to assure compliance. K 038 Lakebridge Health Care Center belief its current practices were in complia with the applicable standard of care but in order to respond to this citatif from the surveyors, the facility is tall the following additional actions: Corrective Actions for Targeted Area It was determined that the cited delayed-egress magnetic locking hardware relays were damaged due a recent power surge. The cited delayed-egress magnetic locking hardware was repaired by the facility contracted vendor, Fleenor Security, 7/16/13.	eves ance on king	7/26/13
<u> </u>							
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:50LV21

Facility ID: YN9008

If continuation sheet Page 6 of 12

OLIVIE	NO FOR WEDICARE	& MEDICAID SERVICES			MB NO. 0938-039	
STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	<u>. </u>	445358	B. WING		07/40/0040	
	PROVIDER OR SUPPLIER RIDGE HEALTH CARE	CENTER		TREET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE	07/16/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF TH	DRE COMPLETION	
K 038	Exit access is arran	ge 3 ged so that exits are readily es in accordance with section	K 038	Idontification - COV		
	Based on observati determined the facil twelve (12) delayed upon activation of the Findings include: Observation and into the Maintenance Dir 9:30 p.m. confirmed delayed-egress mag to release with fire a shop, by rooms 605.	erview during the fire drill with a		Systematic Changes Facility staff were in-serviced on 7/19/13 regarding the codes for delayed-egress magnetic locking das codes change, staff will be againserviced regarding proper codes. staff will be in-serviced upon new employee orientation regarding prodes. The Maintenance Director vaudit delayed-egress magnetic lock hardware weekly to assure complish	n in- New Toper will king	
K 045 SS=D	Three (3) of ten (10) the code for releasin The Therapy gym de to operate. These findings were Supervisor and ackn Administrator during 15, 2013. NFPA 101 LIFE SAF Illumination of means discharge, is arrange lighting fixture (bulb)	verified by the Maintenance owledged by the the exit conference on July ETY CODE STANDARD of egress, including exit ed so that failure of any single will not leave the area in s not refer to emergency	K 045	Monitoring The Maintenance Director will reported the above audits monthly the facility's Performance Improved Committee for review and recommations. This Committee consists of the Administrator, Medical Director Director of Nursing, Assistant Director of Nursing, Dietary Manager, Constant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed	y to ment nend- of or, tor ult- ent	

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 07/18/2013 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		445358	B. WING	;		07/	16/2013
	PROVIDER OR SUPPLIER RIDGE HEALTH CARE	CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE JOHNSON CITY, TN 37604	 -	10/20 - 0
(X4) ID PREFIX TAG	[(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 038	Exit access is arran	age 3 nged so that exits are readily nes in accordance with section	КС	038	by the Administrator and the Main nance Director to assure compliance		7/26/13
	Based on observati determined the facility twelve (12) delayed upon activation of the Findings include: Observation and into the Maintenance Director of the Maintenance D	terview during the fire drill with irector, on July 15, 2013 at dexit doors with gnetic locking hardware failed alarm activation by the beauty 5, 208, 713, kitchen exit, by se, main entrance and dining staff interviewed did knowing the doors. elayed egress function failed a verified by the Maintenance			K 045 Lakebridge Health Care Center belia its current practices were in compli with the applicable standard of care but in order to respond to this citat from the surveyors, the facility is ta the following additional actions: Corrective Actions for Targeted Area	iance e, iion iking	

FORM CMS-2567(02-99) Previous Versions Obsolete

15, 2013.

SS=D

Supervisor and acknowledged by the

K 045 NFPA 101 LIFE SAFETY CODE STANDARD

Administrator during the exit conference on July

Illumination of means of egress, including exit

lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency

discharge, is arranged so that failure of any single

lighting in accordance with section 7.8.) 19.2.8

Event ID:50LV21

Facility ID: TN9008

affected.

K 045

If continuation sheet Page 8 of 12

The cited outside courtyard lights/bulbs

and the wall-mounted light were

Identification of Other Areas with

Outside lighting in the courtyard and

other areas have the potential to be

replaced on 7/18/13.

Potential to be Affected

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: -COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445358 B. WING 07/16/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE LAKEBRIDGE HEALTH CARE CENTER JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 045 | Continued From page 4 Systematic Changes K 045 On 7/18/13, the facility's outside lighting was checked by the Maintenance Director and was found to be This STANDARD is not met as evidenced by: functioning properly. The Maintenance Based on observation and interview, it was determined the facility failed to ensure exit paths Director will audit facility lighting were lighted. monthly to assure compliance. The findings include: Observation and interview with the Maintenance Monitoring Director, on July 15, 2013 at 9:40 p.m. confirmed the outside courtyard lights failed to illuminate The Maintenance Director will the means of egress to exit the courtyard and the report audit results monthly to the wall mounted light was burnt out. Performance Improvement This finding was verified by the Maintenance Supervisor and acknowledged by the Committee for review and recom-Administrator during the exit conference on July mendations. This Committee 15, 2013. consists of the Administrator, Medical K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 Director, Director of Nursing, Assistant SS=D Generators are inspected weekly and exercised Director of Nursing, Dietary Manager, under load for 30 minutes per month in Consultant Pharmacist, MDS and accordance with NFPA 99. Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director to assure 7/26/13 compliance. This STANDARD is not met as evidenced by: K 144 Based on observation and interview, the facility failed to ensure the Automatic Transfer switch location was provided with battery-powered Lakebridge Health Care Center believes emergency lighting. its current practices were in compliance The findings include: with the applicable standard of care, but in order to respond to this citation

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 50LV21

Facility ID: TN9008

If continuation sheet Page 9 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		A MEDICAID SERVICES	,		Oi	<u>MB NO</u>	. 0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JIÉDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
-		445358	B. WING	·		07/	16/2013
•	PROVIDER OR SUPPLIER	CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 15 WOODLAWN DRIVE IOHNSON CITY, TN 37604		10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 144 K 147 SS=D	Observation and int Director, on July 15 confirmed the emer Transfer switch local battery-powered em This finding was versupervisor and ack Administrator during 15, 2013 NFPA 101 LIFE SALE Electrical wiring and with NFPA 70, National States on observation determined the facili extension cords. The findings include Observation and interestor, on July 15, 10:10 p.m. confirme in resident rooms 20. This finding was veriful Supervisor and acknowledges.	erview with the Maintenance, 2013 at 10:40 p.m. gency generator Automatic ation was not provided with nergency lighting, rified by the Maintenance nowledged by the githe exit conference on July FETY CODE STANDARD I equipment is in accordance and Electrical Code, 9.1.2 I not met as evidenced by: on and interview, it was ity failed to prohibit the use of exview with the Maintenance 2013 between 7:30 p.m. and differ the use of extension cords 17, 505, and 711. I fied by the Maintenance	K 1	47	from the surveyors, the facility is to the following additional actions: Corrective Actions for Targeted Are The automatic transfer switch local had emergency lighting on the date the survey. Unfortunately, during survey, it was not located nor indict to the surveyor. Identification of Other Areas with Potential to be Affected The emergency generator could be affected if lighting was not provided the automatic switch. Systematic Changes On 7/18/13, the emergency lighting provided for the emergency transfer switch was audited by the Maintenance Director and was found to be in profunctioning order. The Maintenance Director will audit monthly the facil emergency lighting to assure it is functioning properly.	eas tion e of ated d for	
			,		Monitoring The Maintenance Director will repo audit results monthly to the Performance Improvement Commit for review and recommendations. To Committee consists of the Administrator, Medical Director,	tee	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NO IMPERO		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:		ING 01 - MAIN BUILDING 01		MPLETED		
MANEGE	ME OF PROVIDER OR SUPPLIER		B. WING			7/16/2013		
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP 115 WOODLAWN DRIVE JOHNSON CITY, TN 37604		110/2013		
(X4) ID PREFIX - TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF	ION SHOULD BE HE APPROPRIATE:	(X5) COMPLETION DATE		
K 144 K 147 SS=D	Observation and int Director, on July 15 confirmed the emer Transfer switch local battery-powered em This finding was ver Supervisor and ack Administrator during 15, 2013 NFPA 101 LIFE SAF	erview with the Maintenance, 2013 at 10:40 p.m. gency generator Automatic ation was not provided with pergency lighting.	K 14	Consultant Pharmacist, I Assessment Nurse, Hous Supervisor, Maintenance Social Services Director. Committee's recomment followed up by the Admitthe Maintenance Director.	ager, MDS and ekeeping Director, and The dations will be nistrator and	7/26/13		
	determined the facility determined the facility extension cords. The findings include: Observation and interpretor, on July 15, 10:10 p.m. confirmed in resident rooms 20. This finding was verify supervisor and acknowledges.	rview with the Maintenance 2013 between 7:30 p.m. and I the use of extension cords 7, 505, and 711.		Lakebridge Health Care Coits current practices were with the applicable standabut in order to respond to from the surveyors, the fathe following additional accordance of the Mainte Extension cords were remainmediately by the Mainte Director from resident from and 711. Identification of Other Area	in compliance and of care, this citation cility is taking citions: seted Areas oved enance ms 207, 505,			
				Potential to be Affected Resident rooms, in addition 207, 505, and 711, were ch	to rooms			

FORM APPROVED OMB NO. 0938-0391

AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY MPLETED
	·	445358	B. WING			07	16/2013
	PROVIDER OR SUPPLIER	CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 15 WOODLAWN DRIVE OHNSON CITY, TN 37604	<u> </u>	10/20 (3
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BF	(X5) COMPLETION DATE
K 144 K 147 SS=D	Observation and into Director, on July 15 confirmed the emer Transfer switch local battery-powered em This finding was ver Supervisor and ack Administrator during 15, 2013 NFPA 101 LIFE SAI Electrical wiring and with NFPA 70, National Conference of the facility of the findings included the facility of the findings included the finding was versupervisor and acknowledged the finding was versupervisor a	derview with the Maintenance 1, 2013 at 10:40 p.m. 1, 2014 with mergency lighting. 1, 2015 with empty lighting. 1, 2015 with empty lighting. 1, 2016 with empty lighting. 1, 2016 with empty lighting. 1, 2017 with empty lighting. 2, 2, 2, 2, 2, 3, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4,	K1	47	Maintenance Director on 7/18/13 ensure that no other rooms had extension cords, and none were for Systematic Changes Weekly room audits will be completed by the Maintenance Director and Administrator to ensure that reside rooms meet life safety code standincluding assurance that no extension cords are in place. Monitoring The Maintenance Director will repaudit results monthly to the Perforance Improvement Committee for review and recommendations. The Committee consists of the Administrator, Medical Director, Director Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Housekeeping Supervisor, Maintenance Director, and Social	eted ent ard, sion ort rm- is	
	Administrator during 15, 2013.	the exit conference on July			Services Director. The Committee' recommendations will be followed by the Administrator and the Main nance Director to assure compliant:	up te-	7/26/13 -